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ABSTRACT

Major modifications in the diagnostic nomenclature used in the Diagnostic and Statistical Manual of Mental Disorders -III- Revised (DSM-III-R). Discussions of the modifications is preceded by an introduction to diagnosis in counseling and a brief introduction to the DSMs. The process for revising the DSM is described. Modifications in these classifications are described: (1) disorders usually first evident in infancy, childhood, or adolescence; (2) organic mental syndromes and disorders; (3) psychoactive substance use disorders; (4) schizophrenia; (5) delusional (paranoid) disorder; (6) psychotic disorders not elsewhere classified; (7) mood disorders; (8) anxiety disorders; (9) somatoform disorders; (10) dissociative disorders; (11) sexual disorders; (12) sleep disorders; (13) factitious disorders; (14) impulse control disorders not elsewhere classified; (15) adjustment disorder; (16) psychological factors affecting physical condition; (17) personality disorders; (18) V codes; and (19) additional codes. The Multiaxial Diagnosis system is described. The report concludes that it is imperative for mental health counselors to keep appraised of diagnostic revisions and the appropriate use of the multiaxial system in order to provide accountable professional counseling services. (ABL)

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DSM-III-R: Professional Implications and Revisions for Mental Health Counselors

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Abstract

Major revisions to DSM-III and changes in the multiaxial diagnostic system are presented.

DSM-III-R: Professional Implications and Revisions for Mental Health Counselors

Mental health counselors are increasingly seeking and receiving licensure at the independent practice level, setting the stage for more accountability and third-party insurance reimbursements. This professional recognition and responsibility will require counselors to have knowledge in the use of the Diagnostic and Statistical Manual of Mental Disorders - Revised (DSM-III-R) of the American Psychiatric Association (APA) (1987).

The DSM-III was first introduced in the counseling literature by Seligman (1983) following three years of instituted use in clinical settings. Four years later the DSM-III was revised. This article presents the major modifications in the diagnostic nomenclature, preceded by an introduction to diagnosis in counseling and a brief introduction to the DSMs.

Rationale for Diagnosis

A current trend in counseling reflects that approximately 50% of counselor education students are enrolling in community agency counseling programs, and about 70% are seeking employment in non-school settings such as community mental health centers, social agencies, and substance abuse clinics (Richardson & Bradley, 1983). Such settings often require DSM-III-R diagnoses for

accountability, record keeping, treatment planning, research and evaluation, and quality assurance. Seligman (1983) indicated that counselors in private practice must also provide a diagnosis for those clients with reimburseable insurance coverage.

Utilization of the DSM-III-R

The fact that the DSM-III-R is a manual indicates much about its intended use. Like other manuals, the DSM-III-R is best utilized as a reference text. Seligman (1983) suggested that comfortable use will require several months of frequent diagnosing. The neophyte user can enhance the diagnostic learning process by attending a workshop or seeking assistance from a clinician with seasoned experience. College coursework in abnormal psychology is also helpful (and fortunately required of many community agency and mental health counseling students).

Overview of the DSMs

The DSM-III was published in 1980, following almost thirty years of utilization of the DSM-I and DSM-II (APA, 1952; 1968). Descriptions of mental disorders and their diagnostic categories first appeared in DSM-I, which focused on Adolf Meyer's psychobiologic views. The DSM-II featured a diagnostic system that for the most part did not adhere to a particular theoretical framework. The DSM-III reflected the most current research knowedge

regarding mental disorders and maintained compatibility with the International Classification of Diseases - Ninth Edition (ICD-9). The DSM-III's major contribution was the use of a multiaxial approach to evaluation and its usefulness in various settings by clinicians, researchers, and administrators with varying theoretical orientations.

The Revision Process

Over 200 advisory committee members of the APA implemented similar goals which guided the development of DSM-III. These included:

(1) clinical usefulness for making treatment and management decisions in varied clinical settings;

(2) reliability of the diagnostic categories;

(3) acceptability to clinicians and researchers of varying theoretical orientations;

(4) usefulness for educating health professionals;

(5) maintenance of compatibility with ICD-9-CM codes;

(6) avoidance of new terminology and concepts that break with tradition except when clearly needed;

(7) attempting to reach consensus on the meaning of necessary diagnostic terms that have been used inconsistently, and avoidance of terms that have outlived their usefulness;

(8) consistency with data from research studies bearing on the validity of diagnostic categories;

(9) suitability for describing subjects in research studies;

(10) responsiveness, during the development of DSM-III-R, to critiques by clinicians and researchers (APA, 1987, pp. xix-xx).

A majority of the revisions to the DSM-III were made on the basis of experts' actual clinical experiences with the manual. Imprecise data were reconsidered making the diagnostic categories more consistent with research findings and historical and clinical concepts. It is important to note that, according to the APA (1987), the impact of a particular revision on the possibility of reimbursement for treatment was rarely mentioned during the revision process.

The Revised Diagnostic Classifications

In this section, each of the diagnostic categories is discussed in the order of presentation in the DSM-III-R. All major changes, alterations, and additions to the classification are shown in italics.

Disorders Usually First Evident in Infancy, Childhood, or Adolescence

The most significant revisions in the DSM-III are in this category. Mental Retardation and Specific and Pervasive Developmental Disorders have been combined under a new classification, Developmental Disorders. This is now a more logical classification since these disorders are all first evident early in life. Intelligence levels used as guides for distinquishing the Mental Retardation diagnoses have been revised to reflect

some degree of overlap between IQs.

Autistic Disorder replaces Infantile Autism. This new diagnosis includes a more comprehensive manifestation of the disorder at different developmental levels. Childhood Onset Pervasive Developmental Disorder has been excluded. When a child's impairment does not meet the criteria for Autistic Disorder or any of the schizophrenic-type disorders, Pervasive Developmental Disorder Not Otherwise Specified should be used. Other diagnoses throughout the infant, child, and adolescent classifications have been altered in order to include larger age ranges and similar or associated psychological or behavioral features. Additionally, many Axis I and II diagnoses now include time frame criteria.

Many of the diagnoses under Specific Developmental Disorders have been reworded. For example, Developmental Language Disorder: Expressive Type is now listed as Developmental Expressive Language Disorder. A new category within this area, Developmental Coordination Disorder, has also been added. This diagnosis refers to motor coordination difficulites that interfere with academic achievement or daily living activities.

Attention Deficit Disorder with Hyperactivity is now indexed as Attention Deficit Hyperactivity Disorder or ADHD. The Attention Deficit Disorder without Hyperactivity diagnosis has been discontinued since,

according to experts in the field, it was rarely being made. Undifferentiated Attention Deficit Disorder is now the appropriate diagnosis for attention difficulties exclusive of hyperactivity.

A new category Disruptive Behavior Disorders, which includes ADHD, Oppositional Defiant Disorder and Conduct Disorder, has been established. Conduct disorder now subsumes solitary, group, and undifferentiated types. The DSM-III (under)socialized and (non)aggressive subtypings were dropped due to their variance with the research findings which suggested that the social setting itself is the differential in making the conduct disorder diagnosis. Oppositional Disorder has been broadened to Oppositional Defiant Disorder to better distinguish it from the Conduct Disorder diagnosis.

Bulimia has been revised to Bulimia Nervosa in order to reflect the important relationship it has with Anorexia Nervosa. The weight loss criteria for Anorexia Nervosa has also been lowered in order to be less restrictive. Moreover, at least three consecutive, missed menstrual cycles are now required to make this eating disorder diagnosis. Less common diagnoses with the term "atypical" have been changed throughout the DSM-III-R to the term Not Otherwise Specified (NOS). For example, Atypical Eating Disorder is now Eating Disorder NOS.

Tourette's Disorder and other sudden, nonrhythmic motor movement and vocalization disturbances have been listed under the new classification Tic Disorders. The DSM-III rubric for these difficulties, Stereotyped Movement Disorders, has been eliminated.

Diagnoses within the DSM-III classification, Other Disorders with Physical Manifestations, have been listed elsewhere and the classification dropped. As a result, the category Elimination Disorders was created and includes Functional Encopresis and Functional Enuresis.

Similarly, Stuttering was moved to a new classification, Speech Disorders Not Elsewhere Classified. This section also includes the new diagnosis Cluttering. The features of this speech disorder include typically unconscious faulty syntax and articulation errors.

Sleepwalking and Sleep Terror Disorders were combined and now belong to a new category Sleep Disorders, which is separate from the infant, childhood, and adolescent diagnoses and discussed later.

Organic Mental Syndromes and Disorders

The DSM-III differentiated between Organic Mental "Syndromes" and "Disorders", however, this is more clearly presented in the revised edition, as indicated by the category's title which now includes syndromes. Syndromes

are more clearly described as psychological and behavioral anomalies in which no certain etiology exists. Disorders are described as having a presumed or known cause.

Organic Affective Syndrome has been changed to Organic Mood Syndrome with three subtypes, manic, depressed, and mixed. Organic Anxiety Disorder, which was only recognized in DSM-III, is now included as a specific diagnosis. In addition, many of the Organic Mental Syndromes were given "disorder" classifications. For example, Organic Personality Syndrome is now Organic Personality Disorder. This diagnosis should also specify explosive type if rage or aggression are predominant.

The broad DSM-III category Substance-Induced Organic Mental Disorder has had psychoactive added to the beginning of the category for clarity. PCP- and hallucinogen-induced disorders are now covered more comprehensively and a delirium component has been added as an additional diagnostic option for these diagnoses.

Psychoactive Substance Use Disorders

The criteria for drug abuse and dependence in DSM-III-R have been changed. Essentially, abuse is reserved for disturbances in which the features for dependence have not been met, although a maladaptive pattern of use is evident. Cocaine and Hallucinogen Dependence, as well as Inhalent Abuse and Dependence, have been added as

new categories. Dependence on a Combination of Substances has been excluded, with a more specific diagnosis, Polysubstance Dependence taking its place. Moreover, Tobacco Dependence has been renamed Nicotine Dependence. (It is interesting to note that there is no diagnosis in DSM-III-R for nicotine abuse).

Schizophrenia

Schizophrenic Disorders has been shortened to simply Schizophrenia in DSM-III-R. The age requirement has been eliminated in order to account for childhood onset. Schizophrenia, Paranoid Type, now has stable-type as a suffix if the schizophrenic disturbance is clearly and exclusively of a paranoid nature. Likewise, the new suffix late onset is added if the disturbance develops after age forty-five.

Delusional (Paranoid) Disorder

Paranoid Disorders has been altered to Delusional (Paranoid) Disorder to more clearly define the delusional emphasis. Six specific delusional themes have also been added, including erotomanic, grandiose, jealous, persecutory, somatic, and undifferentiated types.

Psychotic Disorders Not Elsewhere Classified

Schizophreniform Disorder has had a diagnostic suffix added, namely without good prognostic features or with good prognostic features. DSM-III-R continues to list the controversial and somewhat confusing diagnosis

of Schizoaffective Disorder, and bipolar and depressed types have been added as suffixes.

Mood Disorders

The major modification in this category is that Affective Disorders have been renamed Mood Disorders due to the latter being more descriptive. Major Depression now has a chronic and melancholic type suffix attached. Melancholic type may be specified if the depressive episode is manifested by a loss of feeling pleasure. The option of a seasonal pattern suffix has been included for Bipolar Disorder and Major Depression. Seasonal pattern is used if at least three episodes of the mood disturbance are evidenced in three years (at least two years consecutively), and lasting for a sixty-day period. A full remission or change must also be evidenced following the seasonal pattern, and the pattern cannot be attributable to seasonal employment.

Dysthymia, the shortened term for Dysthymic Disorder now has a primary or secondary, and early or late onset alternative suffixes. Similarly, Cyclothymic Disorder has been revised to Cyclothymia and includes more concentrated criteria for the diagnosis.

Anxiety Disorders

Phobic Disorders as a separate classification has been dropped in the revision of the DSM-III. Agoraphobia is now classified as subtypes of Panic Disorder. More

specifically, the new listings are Panic Disorder with Agoraphobia and Panic Disorder without Agoraphobia. Panic attacks and agorophobic avoidance diagnoses must include current level of severity. These levels include mild, moderate, severe, in partial remission, and in full remission. Agoraphobic symptoms that do not meet all the criteria for a panic diagnosis are listed as Agoraphobia without History of Panic Disorder. The diagnosis Social Phobia now includes a generalized type stipulation if the phobic situation is predominantly social. The time requirement for the diagnosis of Generalized Anxiety Disorder has been increased form one to six months in order to exclude more transient anxiety states. The acute and chronic suffixes for Post-traumatic Stress Disorder (PTSD) have been omitted, however, delayed onset should be specified if symptoms begin at least six months after the trauma. Specific criteria regarding the diagnostic symptoms of PTSD in children have been added.

Somatoform Disorders

Body Dysmorphic Disorder, which is described as a normal-appearing individual's preoccupation with an imagined defect in appearance, is a new diagnosis in DSM-III-R. This diagnosis was previously termed Dysmorphophobia and listed only as a symptom under Atypical Somatoform Disorder. Because there are so many cases that have many of the symptoms of somatoform

disorders, but do not meet all of the criteria for a formal diagnosis, the new diagnosis of Undifferentiated Somatoform Disorder was created. Psychogenic Pain Disorder has been renamed Somatoform Pain Disorder because some cases may not exibit direct evidence of a psychological etiology. In addition, Conversion Disorder must be specified by a single episode or recurrent suffix.

Dissociative Disorders

These disorders, which typically feature disturbances of memory, identity, and consciousness, have not been significantly revised in the DSM-III-R. However, the criteria for these diagnoses have been made somewhat more explicit.

Sexual Disorders

Psychosexual Disorders has been shortened to Sexual Disorders. The Gender Identity Disorders, including Transsexualism, have been moved to the major classification of Disorders Usually First Evident in Infancy, Childhood, and Adolescence, since they almost always begin at an early age. Zoophilia has been dropped as a separate diagnosis since it is rarely diagnosed separate from another disorder. It is listed, however, as an example of a symptom in the classification Paraphilia NOS. Frotteurism, also a paraphilia, is a new diagnosis in the DSM-III-R. The essential features of

this diagnosis include the obtaining of sexual gratification by rubbing against nonconsenting partners. Pedophilia now includes same sex, opposite sex, same and opposite sex, and limited to incest suffixes. In addition, exclusive or nonexclusive type suffixes are specified dependent on the pedophile's attraction or not to children only.

The title Psychosexual Dysfunctions has been revised to Sexual Dysfunctions with several suffixes including psychogenic and/or biogenic, lifelong or acquired, and generalized or situational. If the sexual dysfunction is biogenic only, it should be coded on Axis III. Inhibited Sexual Desire Disorder has been renamed Hypoactive Sexual Desire Disorder, and Sexual Aversion Disorder has been added for diagnosing individuals who avoid sexual contact. Female and Male Sexual Arousal Disorders and Male Erectile Disorder have also been added.

Sexual Pain Disorders is a new classification, however, the diagnoses Functional Dyspareunia and Vaginismus are essentially the same. Ego-dystonic Homosexuality has been dropped due to its rare use in clinical situations. Diagnostic criteria previously fitting this category can be vaguely identified in the Sexual Disorder NOS classification.

Sleep Disorders

Sleep Disorders is a new category in the DSM-III-R and includes Dyssomnias and Parasomnias. Dyssomnias (i.e., disturbances in the duration, quality, and intensity or timing of sleep) include Insomnia, Hypersomnia, and Sleep-Wake Schedule Disorders. Parasomnias (i.e., disturbances not affecting sleep or awakeness) include Dream Anxiety Disorder (Nightmare Disorder), Sleep Terror Disorder, and Sleepwalking Disorder.

Factitious Disorders

This clasification, typified by intentionally produced physical and psychological symptoms, has not undergone significant changes. The diagnostic criteria concerning factitious behavior, however, has been changed from voluntary to intentional.

Impulse Control Disorders Not Elsewhere Classified

Trichotillomania, or the pulling out of one's hair, has been added to the nomenclature as an impulse control disorder. Isolated Explosive Disorder has been discontinued because of a problem with misdiagnosis. It appears that making such a diagnosis on a single, isolated behavioral act creates the potential for an inaccurate diagnosis.

Adjustment Disorder

Adjustment Disorders have virtually been unchanged, however, Adjustment Disorder with Physical Complaints has been added. This new diagnosis should be considered when adjustment disorders feature somatic complaints of less than six months duration.

Psychological Factors Affecting Physical Condition

This category has not been revised, however, the physical condition or disorder should be recorded on Axis III.

Personality Disorders

Compulsive Personality Disorder has been changed to Obsessive Compulsive Personality Disorder in order to reflect the cognitive features of the disturbance. DSM-III-R Personality Disorders have been grouped into three clusters. Cluster A includes Paranoid, Schizoid, and Schizotypal Personality Disorders. These diagnoses are represented by odd and eccentric behavior. Cluster B includes Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. These diagnoses are often depicted by emotional, dramatic, and erratic behavior. Avoidant, Dependent, Obsessive Compulsive, and Passive Aggressive Personality Disorders comprise Cluster C. The common features of these diagnoses are anxiety and fearfulness.

V Codes

The only significant alteration among these diagnoses is that Borderline Intellectual Fuctioning is now coded on Axis II.

Additional Codes

No diagnosis, Diagnosis Deferred, and Unspecified Mental Disorder (Nonpsychotic) essentailly remain unchanged. However, Unspecified Mental Disorder (Nonpsychotic) can also be used to list disorders not included in the DSM-III-R classification. For example, "proposed diagnostic categories" such as Self-defeating Personality Disorder can be listed under this additional code.

The Multiaxial System

Like the DSM-III, all mental disorder diagnoses in the DSM-III-R are coded on Axes I or II. Disorders that do not meet the criteria for a specific mental disorder, but are a source of impairment (V Codes), are listed on Axis I. Only Personality Disorders and Developmental Disorders are coded on Axis II. The DSM-III-R now includes Mental Retardation diagnoses and Borderline Intellectual Functioning (a V Code), on Axis II. The following is a description of the Multiaxial Diagnosis.

Axis I: Clinical Syndromes and V Codes (V codes - are not attributable to a mental disorder)

Axis II: Personality Disorders and Developmental Disorders (including Mental Retardation and Borderline Intellectual Functioning)

Axis III: Physical Disorders and Conditions

Axis IV: Severity of Psychosocial Stressors

Axis V: Global Assessment of Functioning (GAF) (Current GAF & Highest GAf past year)

Axis IV, Severity of Psychosocial Stressors, should include acute onset or predominently enduring circumstances for symptoms enduring less than and greater than six months, respectively.

Axis V, Highest Level of Adaptive Functioning Past Year, has been changed to Global Assessment of Functioning (GAF). Two GAF measures are implemented. First, Current GAF assesses functioning level at the time of the diagnostic evaluation. Second, the Highest GAF Past Year assesses functioning level for several months during the past year. A numeric scale, ranging form 1-90, is provided for making the GAF evaluations.

DSM - III - R Multiaxial Diagnosis Example

Axis I 309.89 Post-traumatic Stress Disorder, Delayed Onset
V62.30 Occupational Problem
AXIS II V71.09 No Diagnosis on Axis II
AXIS III Pneumocystis pneumonia; kaposis sarcoma
AXIS IV Psychosocial Stressors: Poor health, chronic; death of parents
Severity: 5 - Extreme (predominantly enduring circumstances)
AXIS V Current GAF: 50
Highest GAF Past Year: 65

Summary

This article has presented the major revisions in the DSM-III diagnostic nomenclature and concomitant changes in the multiaxial system. Mental health counselors working in a variety of settings and private practice are increasingly required to provide a DSM-III-R diagnosis for their clients. As a result, it is imperative that mental health counselors keep appraised of diagnostic revisions and the appropriate use of the multiaxial system in order to provide accountable professional counseling services.

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